Patient Information Request form

In accordance with HIPAA laws, I sign this authorization for transfer of my medical records

Patient Information:

Name: _____
Date of Birth: _____
Information Requested: _____

_____

Patient Signature: _____

Or Patient Representative: _____
Relation to the Patient:_____

Information from:

Facility: _____
Phone #: _____

Fax #: _____

Information to:

HENDERSON
INTERNAL MEDICINE

90 S Stephanie St., Ste 110
Henderson, NV 89012

Phone: 702-305-3293
702-848-3420
Fax: 702-333-0822